OHS/CAD-200 (7/03)

Instructions

Print legibly or type information. Sign at bottom.
Complete ***all*** sections of this form.
Return white copy to the address at right.
Retain canary copy for your records.

State of Michigan
Department of Consumer & Industry Services
Bureau of Health Services
Complaint and Allegation Division
P.O. Box 30670
Lansing, Michigan 48909-8170
http://www.michigan.gov/bhser/

Office Use Only

File #

ALLEGATION FORM

Authority: P.A. 368 of 1978, as amended.
Completion: Voluntary Penalty: None

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board do not assist citizens seeking return of their money or other personal remedies.** I am, however, submitting this information so that it may be determined if licensing action against this practitioner should be considered.

Information About You			Complaint Filed Against	
Your Name			Practitioner's Name	
Street Address			Street Address	
City			City	
State	ZIP Code	County	State	ZIP Code
Patient's Name			Practitioner's Telephone Number ( )	
Your Telephone Number Home: ( ) Work: ( )			Treatment/Incident Date	

Check One:

☐ Allopathic Physician (MD)	☐ Emergency Medical Services Personnel	☐ Nursing Home Administrator	☐ Pharmacist	☐ Psychologist
☐ Chiropractor	☐ Marriage & Family Therapist	☐ Occupational Therapist	☐ Physician's Assistant	☐ Sanitarian
☐ Counselor	☐ Nurse (LPN or RN)	☐ Optometrist	☐ Physical Therapist	☐ Social Worker
☐ Dentist	☐ Nurse Aide (CENA)	☐ Osteopathic Physician (DO)	☐ Podiatrist	☐ Veterinarian

Is there court action pending?	Enter Your Attorney's Name	May we release your name and this information to the practitioner?	Will you testify at an Administrative Hearing if necessary?
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Give details of your concerns (who, what, when, where, how, etc. Use additional sheets if necessary).

Signature _____ Date _____

Michigan Department of Consumer & Industry Services
Bureau of Health Services
OHS-0206 (4/03)

File #_____

TREATMENT DATA FORM

NAME OF PATIENT:

_____

Date of Birth: _____ **Social Security Number:** _____

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULLNAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disability Act, you may make your needs known to this agency.

Completion: Voluntary Penalty: None

File #_____

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
Bureau of Health Services

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, _____ hereby authorize _____
Patient, Client, Representative Name — Name of doctor, hospital, program or other custodian of record

_____
Address of doctor, hospital, program, or other custodian of records

to release information contained in the records of:

_____ _____ _____
Patient Name — Date of Birth — Social Security Number

to the individuals or organizations listed and only under the following conditions:

1. **Name of person(s) or organization(s) to whom disclosure is to be made:**
   Department of Consumer and Industry Services, Bureau of Health Services, Complaint and Allegation Division, P.O. Box 30670, Lansing, Michigan 48909 or the Attorney General.

2. **Specific type of information to be disclosed:**
   Any and all **MEDICAL and SUBSTANCE ABUSE** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. This includes records relating to communicable diseases and serious communicable diseases including but not limited to: **AIDS, ARC** and **HIV**.

3. **The purpose and need for such disclosure:**
   I understand that the Department of Consumer and Industry Services, Bureau of Health Services and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that by sending a written revocation to the doctor, hospital or other custodian of records I may revoke this authorization at any time, except to the extent that action has already been taken in reliance thereon. This authorization (unless expressly revoked earlier) **expires 1 year from the date provided below.**

5. This information is released subject to the provisions of the Michigan Mental Health Code and Federal Public Act 258 (1974) and Federal Regulation (42 CFR, Part 2).

A copy of this authorization shall serve in the stead of the original.

_____ _____
Patient/Client or Representative's Signature — Date Signed

_____ _____
Witness Signature — Date Witnessed

_____
Date Prepared:

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Completion: Voluntary Penalty: None
Authority: P.A. 368 of 1978, as amended
OHS-0207 (4/03)